Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: CHRISTUS HOSPITAL-ST. ELIZABETH P.O. BOX 848060 DALLAS, TX 75284	MFDR Tracking #:	M4-10-0047-01
Respondent Name and Box #: TEXAS MUTUAL INSURANCE CO. Box #: 54		

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

The Requestor did not submit a Position Statement.

Principle Documentation:

1. DWC 060
2. Medical bills and EOBs
3. Medical Documentation
4. Total Amount Sought $11,356.99

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Statement, dated November 10, 2009 states, in part, "…The date of service in dispute is 6/14/07. DWC MDR date stamped received the requestor's DWC-60 on 8/31/09. This places the disputed date outside of DWC MDR's jurisdiction. Texas Mutual urges DWC MDR to dismiss the requestor's request for fee dispute resolution…."

Principle Documentation:

1. Response to DWC060

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed CPT Codes	Amount in Dispute	Amount Due
6/14/2007	CAC-W1, CAC-W10, CAC-W4, CAC-97, 480, 719, 730 and 891	C1713-Facility charges	$11,356.99	$0.00
Total Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

1. These services were denied by the Respondent with reason codes:
   - CAC-W1-Workers Compensation State Fee Schedule adjustment
   - CAC-W10-No Maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology.
   - CAC-W4-No additional reimbursement allowed after review of appeal/reconsideration
   - CAC-97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 480-Reimbursement based on the acute care inpatient hospital fee guidelines.
   - 719-Reimbursement at carrier's fair & reasonable cost data unavailable for facility. Additional payment maybe considered if data is submitted.
   - 730-Denied as included in per diem rate.
   - 891-The insurance company is reducing or denying payment after reconsideration.

2. Medical Fee Dispute Resolution (MFDR) received the DWC 060 on August 31, 2009. The date of service in dispute is June 14, 2007. Rule 133.307 (c) (1) (A), states, "(c) Requests. Requests for medical dispute resolution (MDR) shall be filed in the form and manner prescribed by the Division. Requestors shall file two legible copies of the request with the Division. (1) Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The dispute was filed after the one year filing deadline.
3. The Division concludes that this dispute was not eligible for review due the untimely filing of the MFDR request. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d), §413.031 and §413.0311
Rule 133.307

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. §413.031, the Division has determined that the Requestor is entitled to $0.00 reimbursement.

		December 3, 2009
Signature	Medical Fee Dispute Resolution Officer	Date
		December 3, 2009
Authorized Signature	Manager, Medical Fee Dispute Resolution	Date

PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.